

106TH CONGRESS
1ST SESSION

H. R. 2089

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

IN THE HOUSE OF REPRESENTATIVES

JUNE 9, 1999

Mr. BOEHNER introduced the following bill; which was referred to the Committee on Education and the Workforce

A BILL

To amend title I of the Employee Retirement Income Security Act of 1974 to provide new procedures and access to review for grievances arising under group health plans.

1 *Be it enacted by the Senate and House of Representa-*
2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE.**

4 This Act may be cited as the “Group Health Plan
5 Review Standards Act of 1999”.

6 **SEC. 2. SPECIAL RULES FOR GROUP HEALTH PLANS.**

7 (a) IN GENERAL.—Section 503 of the Employee Re-
8 tirement Income Security Act of 1974 (29 U.S.C. 1133)
9 is amended—

1 (1) by inserting “(a) IN GENERAL.—” after
2 “SEC. 503.”;

3 (2) by inserting “(other than a group health
4 plan)” after “employee benefit plan”; and

5 (3) by adding at the end the following new sub-
6 section:

7 “(b) SPECIAL RULES FOR GROUP HEALTH PLANS.—

8 “(1) COVERAGE DETERMINATIONS.—Every
9 group health plan shall—

10 “(A) provide adequate notice in writing in
11 accordance with this subsection to any partici-
12 pant or beneficiary of any adverse coverage de-
13 cision with respect to benefits of such partici-
14 pant or beneficiary under the plan, setting forth
15 the specific reasons for such coverage decision
16 and any rights of review provided under the
17 plan, written in a manner calculated to be un-
18 derstood by the average participant;

19 “(B) provide such notice in writing also to
20 any treating medical care provider of such par-
21 ticipant or beneficiary, if such provider has
22 claimed reimbursement for any item or service
23 involved in such coverage decision, or if a claim
24 submitted by the provider initiated the pro-
25 ceedings leading to such decision;

1 “(C) afford a reasonable opportunity to
2 any participant or beneficiary who is in receipt
3 of the notice of such adverse coverage decision,
4 and who files a written request for review of the
5 initial coverage decision within 90 days after re-
6 ceipt of the notice of the initial decision, for a
7 full and fair review of the decision by an appro-
8 priate named fiduciary who did not make the
9 initial decision; and

10 “(D) meet the additional requirements of
11 this subsection.

12 “(2) TIME LIMITS FOR MAKING INITIAL COV-
13 ERAGE DECISIONS FOR BENEFITS AND COMPLETING
14 INTERNAL APPEALS.—

15 “(A) TIME LIMITS FOR DECIDING RE-
16 QUESTS FOR BENEFIT PAYMENTS, REQUESTS
17 FOR ADVANCE DETERMINATION OF COVERAGE,
18 AND REQUESTS FOR REQUIRED DETERMINA-
19 TION OF MEDICAL NECESSITY.—Except as pro-
20 vided in subparagraph (B)—

21 “(i) INITIAL DECISIONS.—If a request
22 for benefit payments, a request for advance
23 determination of coverage, or a request for
24 required determination of medical necessity
25 is submitted to a group health plan in such

1 reasonable form as may be required under
2 the plan, the plan shall issue in writing an
3 initial coverage decision on the request be-
4 fore the end of the initial decision period
5 under paragraph (10)(I) following the fil-
6 ing completion date. Failure to issue a cov-
7 erage decision on such a request before the
8 end of the period required under this
9 clause shall be treated as an adverse cov-
10 erage decision for purposes of internal re-
11 view under clause (ii).

12 “(ii) INTERNAL REVIEWS OF INITIAL
13 DENIALS.—Upon the written request of a
14 participant or beneficiary for review of an
15 initial adverse coverage decision under
16 clause (i), a review by an appropriate
17 named fiduciary (subject to paragraph (3))
18 of the initial coverage decision shall be
19 completed, including issuance by the plan
20 of a written decision affirming, reversing,
21 or modifying the initial coverage decision,
22 setting forth the grounds for such decision,
23 before the end of the internal review period
24 following the review filing date. Such deci-
25 sion shall be treated as the final decision

1 of the plan, subject to any applicable re-
2 consideration under paragraph (4). Failure
3 to issue before the end of such period such
4 a written decision requested under this
5 clause shall be treated as a final decision
6 affirming the initial coverage decision.

7 “(B) TIME LIMITS FOR MAKING COVERAGE
8 DECISIONS RELATING TO ACCELERATED NEED
9 MEDICAL CARE AND FOR COMPLETING INTER-
10 NAL APPEALS.—

11 “(i) INITIAL DECISIONS.—A group
12 health plan shall issue in writing an initial
13 coverage decision on any request for expedited
14 advance determination of coverage or
15 for expedited required determination of
16 medical necessity submitted, in such reasonable
17 form as may be required under the
18 plan before the end of the accelerated need
19 decision period under paragraph (10)(K),
20 in cases involving accelerated need medical
21 care, following the filing completion date.
22 Failure to approve or deny such a request
23 before the end of the applicable decision
24 period shall be treated as a denial of the

request for purposes of internal review under clause (ii).

“(ii) INTERNAL REVIEWS OF INITIAL DENIALS.—Upon the written request of a participant or beneficiary for review of an initial adverse coverage decision under clause (i), a review by an appropriate named fiduciary (subject to paragraph (3)) of the initial coverage decision shall be completed, including issuance by the plan of a written decision affirming, reversing, or modifying the initial coverage decision, setting forth the grounds for the decision before the end of the accelerated need decision period under paragraph (10)(K) following the review filing date. Such decision shall be treated as the final decision of the plan, subject to any applicable reconsideration under paragraph (4). Failure to issue before the end of the applicable decision period such a written decision requested under this clause shall be treated as a final decision affirming the initial coverage decision.

1 “(3) MEDICAL PROFESSIONALS MUST REVIEW
2 INITIAL COVERAGE DECISIONS INVOLVING MEDICAL
3 APPROPRIATENESS OR NECESSITY OR INVESTIGA-
4 TIONAL ITEMS OR EXPERIMENTAL TREATMENT OR
5 TECHNOLOGY.—If an initial coverage decision under
6 paragraph (2)(A)(i) or (2)(B)(i) is based on a deter-
7 mination that provision of a particular item or serv-
8 ice is excluded from coverage under the terms of the
9 plan because the provision of such item or service
10 does not meet the plan’s requirements for medical
11 appropriateness or necessity or would constitute in-
12 vestigational items or experimental treatment or
13 technology, the review under paragraph (2)(A)(ii) or
14 (2)(B)(ii), to the extent that it relates to medical ap-
15 propriateness or necessity or to investigational items
16 or experimental treatment or technology, shall be
17 conducted by a physician or, if appropriate, another
18 medical professional, who is selected by the plan and
19 who did not make the initial denial.

20 “(4) ELECTIVE EXTERNAL REVIEW BY INDE-
21 PENDENT MEDICAL EXPERT AND RECONSIDERATION
22 OF INITIAL REVIEW DECISION.—

23 “(A) IN GENERAL.—In any case in which
24 a participant or beneficiary, who has received
25 an adverse coverage decision which is not re-

versed upon review conducted pursuant to paragraph (1)(C) (including review under paragraph (2)(A)(ii) or (2)(B)(ii)) and who has not commenced review of the coverage decision under section 502, makes a request in writing, within 30 days after the date of such review decision, for reconsideration of such review decision, the requirements of subparagraphs (B), (C), (D) and (E) shall apply in the case of such adverse coverage decision, if the requirements of clause (i), (ii), or (iii) are met.

“(i) MEDICAL APPROPRIATENESS OR INVESTIGATIONAL ITEM OR EXPERIMENTAL TREATMENT OR TECHNOLOGY.—

The requirements of this clause are met if such coverage decision is based on a determination that provision of a particular item or service that would otherwise be covered under the terms of the plan is excluded from coverage under the terms of the plan because the provision of such item or service—

“(I) does not meet the plan’s requirements for medical appropriateness or necessity; or

1 “(II) would constitute an inves-
2 tigational item or experimental treat-
3 ment or technology.

4 “(ii) CATEGORICAL EXCLUSION OF
5 ITEM OR SERVICE REQUIRING EVALUATION
6 OF MEDICAL FACTS OR EVIDENCE.—The
7 requirements of this clause are met if—

8 “(I) such coverage decision is
9 based on a determination that a par-
10 ticular item or service is not covered
11 under the terms of the plan because
12 provision of such item or service is
13 categorically excluded from coverage
14 under the terms of the plan, and

15 “(II) an independent contract ex-
16 pert finds under subparagraph (C), in
17 advance of any review of the decision
18 under subparagraph (D), that such
19 determination primarily requires the
20 evaluation of medical facts or medical
21 evidence by a health professional.

22 “(iii) SPECIFIC EXCLUSION OF ITEM
23 OR SERVICE REQUIRING EVALUATION OF
24 MEDICAL FACTS OR EVIDENCE.—The re-
25 quirements of this clause are met if—

1 “(I) such coverage decision is
2 based on a determination that a par-
3 ticular item or service is not covered
4 under the terms of the plan because
5 provision of such item or service is
6 specifically excluded from coverage
7 under the terms of the plan, and

8 “(II) an independent contract ex-
9 pert finds under subparagraph (C), in
10 advance of any review of the decision
11 under subparagraph (D), that such
12 determination primarily requires the
13 evaluation of medical facts or medical
14 evidence by a health professional.

15 “(iv) MATTERS SPECIFICALLY NOT
16 SUBJECT TO REVIEW.—The requirements
17 of subparagraphs (B), (C), (D), and (E)
18 shall not apply in the case of any adverse
19 coverage decision if such decision is based
20 on—

21 “(I) a determination of eligibility
22 for benefits,

23 “(II) the application of explicit
24 plan limits on the number, cost, or
25 duration of any benefit, or

1 “(III) a limitation on the amount
2 of any benefit payment or a require-
3 ment to make copayments under the
4 terms of the plan.

5 Review under this paragraph shall not be avail-
6 able for any coverage decision that has pre-
7 viously undergone review under this paragraph.

8 “(B) LIMITS ON ALLOWABLE ADVANCE
9 PAYMENTS.—The review under this paragraph
10 in connection with an adverse coverage decision
11 shall be available subject to any requirement of
12 the plan (unless waived by the plan for financial
13 or other reasons) for payment in advance to the
14 plan by the participant or beneficiary seeking
15 review of an amount not to exceed the greater
16 of (i) the lesser of \$100 or 10 percent of the
17 cost of the medical care involved in the decision,
18 or (ii) \$25, with such dollar amount subject to
19 compounded annual adjustments in the same
20 manner and to the same extent as apply under
21 section 215(i) of the Social Security Act, except
22 that, for any calendar year, such amount as so
23 adjusted shall be deemed, solely for such cal-
24 endar year, to be equal to such amount rounded
25 to the nearest \$10. No such payment may be

1 required in the case of any participant or bene-
2 ficiary whose enrollment under the plan is paid
3 for, in whole or in part, under a State plan
4 under title XIX or XXI of the Social Security
5 Act. Any such advance payment shall be subject
6 to reimbursement if the recommendation of the
7 independent medical expert or experts under
8 subparagraph (D)(iii) is to reverse or modify
9 the coverage decision.

10 “(C) REQUEST TO INDEPENDENT CON-
11 TRACT EXPERTS FOR DETERMINATION OF
12 WHETHER COVERAGE DECISION REQUIRED
13 EVALUATION OF MEDICAL FACTS OR EVI-
14 DENCE.—

15 “(i) IN GENERAL.—In the case of a
16 request for review made by a participant or
17 beneficiary as described in subparagraph
18 (A), if the requirements of clause (ii) or
19 (iii) of subparagraph (A) are met (and re-
20 view is not otherwise precluded under sub-
21 paragraph (A)(iv)), the terms of the plan
22 shall provide for a procedure for initial re-
23 view by an independent contract expert se-
24 lected by the plan under which the expert
25 will determine whether the coverage deci-

1 sion requires the evaluation of medical
2 facts or evidence by a health professional.
3 If the expert determines that the coverage
4 decision requires such evaluation, reconsid-
5 eration of such adverse decision shall pro-
6 ceed under this paragraph. If the expert
7 determines that the coverage decision does
8 not require such evaluation, the adverse
9 decision shall remain the final decision of
10 the plan.

11 “(ii) INDEPENDENT CONTRACT EX-
12 PERTS.—For purposes of this subpara-
13 graph, the term ‘independent contract ex-
14 pert’ means a professional—

15 “(I) who has appropriate creden-
16 tials and has attained recognized ex-
17 pertise in the applicable area of con-
18 tract interpretation;

19 “(II) who was not involved in the
20 initial decision or any earlier review
21 thereof; and

22 “(III) who is selected in accord-
23 ance with subparagraph (G)(i) and
24 meets the requirements of subpara-
25 graph (G)(ii).

1 “(D) RECONSIDERATION OF INITIAL RE-
2 VIEW DECISION.—

3 “(i) IN GENERAL.—In the case of a
4 request for review made by a participant or
5 beneficiary as described in subparagraph
6 (A), if the requirements of subparagraph
7 (A)(i) are met or reconsideration proceeds
8 under this paragraph pursuant to subpara-
9 graph (C), the terms of the plan shall pro-
10 vide for a procedure for such reconsider-
11 ation in accordance with clause (ii).

12 “(ii) PROCEDURE FOR RECONSIDER-
13 ATION.—The procedure required under
14 clause (i) shall include the following—

15 “(I) One or more independent
16 medical experts will be selected in ac-
17 cordance with subparagraph (F) to re-
18 consider any coverage decision de-
19 scribed in subparagraph (A) to deter-
20 mine whether such decision was in ac-
21 cordance with the terms of the plan
22 and this title.

23 “(II) The record for review (in-
24 cluding a specification of the terms of
25 the plan and other criteria serving as

1 the basis for the initial review deci-
2 sion) will be presented to such expert
3 or experts and maintained in a man-
4 ner which will ensure confidentiality
5 of such record.

6 “(III) Such expert or experts will
7 reconsider the initial review decision
8 to determine whether such decision
9 was in accordance with the terms of
10 the plan and this title. Such reconsid-
11 eration shall include the initial deci-
12 sion of the plan, the medical condition
13 of the patient, and the recommenda-
14 tions of the treating physician. The
15 experts shall take into account in the
16 course of such reconsideration any
17 guidelines adopted by the plan
18 through a process involving medical
19 practitioners and peer-reviewed med-
20 ical literature identified as such under
21 criteria established by the Food and
22 Drug Administration.

23 “(IV) Such expert or experts will
24 issue a written decision affirming,
25 modifying, or reversing the initial re-

1 view decision, setting forth the
2 grounds for the decision.

3 “(E) TIME LIMITS FOR RECONSIDER-
4 ATION.—Any review under this paragraph (in-
5 cluding any review under subparagraph (C))
6 shall be completed before the end of the recon-
7 sideration period (as defined in paragraph
8 (10)(L)) following the review filing date in con-
9 nection with such review. The decision under
10 this paragraph affirming, reversing, or modi-
11 fying the initial review decision of the plan shall
12 be the final decision of the plan. Failure to
13 issue a written decision before the end of the
14 reconsideration period in any reconsideration
15 requested under this paragraph shall be treated
16 as a final decision affirming the initial review
17 decision of the plan.

18 “(F) INDEPENDENT MEDICAL EXPERTS.—

19 “(i) IN GENERAL.—For purposes of
20 this paragraph, the term ‘independent
21 medical expert’ means, in connection with
22 any coverage decision by a group health
23 plan, a professional—

“(I) who is a physician or, if appropriate, another medical professional;

“(II) who has appropriate credentials and has attained recognized expertise in the applicable medical field;

“(III) who was not involved in the initial decision or any earlier review thereof;

“(IV) who has not history of disciplinary action or sanctions (including, but not limited to, loss of staff privileges or participation restriction) taken or pending by any hospital, health carrier, government, or regulatory body; and

“(V) who is selected in accordance with subparagraph (G)(i) and meets the requirements of subparagraph (G)(ii).

“(G) SELECTION OF EXPERTS.—

“(i) IN GENERAL.—An independent contract expert or independent medical ex-

1 pert is selected in accordance with this
2 clause if—

3 “(I) the expert is selected by an
4 intermediary which itself meets the re-
5 quirements of clause (ii), by means of
6 a method which ensures that the iden-
7 tity of the expert is not disclosed to
8 the plan, any health insurance issuer
9 offering health insurance coverage to
10 the aggrieved participant or bene-
11 ficiary in connection with the plan,
12 and the aggrieved participant or bene-
13 ficiary under the plan, and the identi-
14 ties of the plan, the issuer, and the
15 aggrieved participant or beneficiary
16 are not disclosed to the expert; or

17 “(II) the expert is selected, by an
18 intermediary or otherwise, in a man-
19 ner that is, under regulations issued
20 pursuant to negotiated rulemaking,
21 sufficient to ensure the expert’s inde-
22 pendence, including selection by the
23 plan in cases where it is determined
24 that a suitable intermediary is not
25 reasonably available,

1 and the method of selection is devised to
2 reasonably ensure that the expert selected
3 meets the independence requirements of
4 clause (ii).

5 “(ii) INDEPENDENCE REQUIRE-
6 MENTS.—An independent contract expert
7 or independent medical expert or another
8 entity described in clause (i) meets the
9 independence requirements of this clause
10 if—

11 “(I) the expert or entity is not
12 affiliated with any related party;

13 “(II) any compensation received
14 by such expert or entity in connection
15 with the external review is reasonable
16 and not contingent on any decision
17 rendered by the expert or entity;

18 “(III) under the terms of the
19 plan and any health insurance cov-
20 erage offered in connection with the
21 plan, the plan and the issuer (if any)
22 have no recourse against the expert or
23 entity in connection with the external
24 review; and

1 “(IV) the expert or entity does
2 not otherwise have a conflict of inter-
3 est with a related party as determined
4 under any regulations which the Sec-
5 retary may prescribe.

6 “(iii) RELATED PARTY.—For pur-
7 poses of clause (i)(I), the term ‘related
8 party’ means—

9 “(I) the plan or any health insur-
10 ance issuer offering health insurance
11 coverage in connection with the plan
12 (or any officer, director, or manage-
13 ment employee of such plan or issuer);

14 “(II) the physician or other med-
15 ical care provider that provided the
16 medical care involved in the coverage
17 decision;

18 “(III) the institution at which
19 the medical care involved in the cov-
20 erage decision is provided;

21 “(IV) the manufacturer of any
22 drug or other item that was included
23 in the medical care involved in the
24 coverage decision; or

1 “(V) any other party determined
2 under any regulations which the Sec-
3 retary may prescribe to have a sub-
4 stantial interest in the coverage deci-
5 sion.

6 “(iv) AFFILIATED.—For purposes of
7 clause (ii)(I), the term ‘affiliated’ means,
8 in connection with any entity, having a fa-
9 milial, financial, or professional relation-
10 ship with, or interest in, such entity.

11 “(H) MISBEHAVIOR BY EXPERTS.—Any
12 action by the expert or experts in applying for
13 their selection under this paragraph or in the
14 course of carrying out their duties under this
15 paragraph which constitutes—

16 “(i) fraud or intentional misrepresen-
17 tation by such expert or experts, or

18 “(ii) demonstrates failure to adhere to
19 the standards for selection set forth in sub-
20 paragraph (G)(ii),

21 shall be treated as a failure to meet the require-
22 ments of this paragraph and therefore as a
23 cause of action which may be brought by a fidu-
24 ciary under section 502(a)(3).

1 “(5) PERMITTED ALTERNATIVES TO REQUIRED
2 INTERNAL REVIEW.—

3 “(A) IN GENERAL.—In accordance with
4 such regulations (if any) as may be prescribed
5 by the Secretary for purposes of this paragraph,
6 in the case of any initial coverage decision for
7 benefits under paragraph (2)(A)(ii) or
8 (2)(B)(ii), a group health plan may provide an
9 alternative dispute resolution procedure meeting
10 the requirements of subparagraph (B) for use
11 in lieu of the procedures set forth under the
12 preceding provisions of this subsection relating
13 review of such decision. Such procedure may be
14 provided in one form for all participants and
15 beneficiaries or in a different form each group
16 of similarly situated participants and bene-
17 ficiaries.

18 “(B) REQUIREMENTS.—An alternative dis-
19 pute resolution procedure meets the require-
20 ments of this subparagraph, in connection with
21 any initial coverage decision, if—

22 “(i) such procedure is utilized solely—

23 “(I) accordance with the applica-
24 ble terms of a bona fide collective bar-
25 gaining agreement pursuant to which

1 the plan (or the applicable portion
2 thereof governed by the agreement) is
3 established or maintained, or

4 “(II) upon election by all parties
5 to such decision,

6 “(ii) the procedure incorporates time
7 limits not exceeding the time limits other-
8 wise applicable under paragraphs (2)(A)(ii)
9 and (2)(B)(ii);

10 “(iii) the procedure incorporates any
11 otherwise applicable requirement for review
12 by a physician under paragraph (3), unless
13 waived by the participant or beneficiary (in
14 a manner consistent with such regulations
15 as the Secretary may prescribe to ensure
16 equitable procedures); and

17 “(iv) the means of resolution of dis-
18 pute allow for adequate presentation by
19 each party of scientific and medical evi-
20 dence supporting the position of such
21 party.

22 “(C) WAIVERS.—In any case in which uti-
23 lization of the alternative dispute resolution
24 procedure is voluntarily elected by all parties in
25 connection with a coverage decision, the plan

1 may require or allow under such procedure (in
2 a manner consistent with such regulations as
3 the Secretary may prescribe to ensure equitable
4 procedures) any party to waive review of the
5 coverage decision under paragraph (3), to waive
6 further review of the coverage decision under
7 paragraph (4) or section 502, and to elect an
8 alternative means of external review (other than
9 review under paragraph (4)).

10 “(6) PERMITTED ALTERNATIVES TO REQUIRED
11 EXTERNAL REVIEW.—A group health plan shall not
12 be treated as failing to meet the requirements of this
13 subsection in connection with review of coverage de-
14 cisions under paragraph (4) if the aggrieved partici-
15 pant or beneficiary elects to utilize a procedure in
16 connection with such review which is made generally
17 available under the plan (in a manner consistent
18 with such regulations as the Secretary may prescribe
19 to ensure equitable procedures) under which—

20 “(A) the plan agrees in advance of the rec-
21 ommendations of the independent medical ex-
22 pert or experts under paragraph (4)(C)(iii) to
23 render a final decision in accordance with such
24 recommendations; and

1 “(B) the participant or beneficiary waives
2 in advance any right to review of the final deci-
3 sion under section 502.

4 “(7) REVIEW REQUIREMENTS.—In any review
5 of a decision issued under this subsection—

6 “(A) the record below shall be maintained
7 for purposes of review in accordance with
8 standards which shall be prescribed in regula-
9 tions of the Secretary designed to facilitate
10 such review, and

11 “(B) any decision upon review which modi-
12 fies or reverses a decision below shall specifi-
13 cally set forth a determination that the record
14 upon review is sufficient to rebut a presumption
15 in favor of the decision below.

16 “(8) COMPLIANCE WITH FIDUCIARY STAND-
17 ARDS.—The issuance of a decision under a plan
18 upon review in good faith compliance with the re-
19 quirements of this subsection shall not be treated as
20 a violation of part 4.

21 “(9) GROUP HEALTH PLAN DEFINED.—For
22 purposes of this section—

23 “(A) IN GENERAL.—The term ‘group
24 health plan’ shall have the meaning provided in
25 section 733(a).

1 “(B) TREATMENT OF PARTNERSHIPS.—

2 The provisions of paragraphs (1), (2), and (3)
3 of section 732(d) shall apply.

4 “(10) OTHER DEFINITIONS.—For purposes of
5 this subsection—

6 “(A) REQUEST FOR BENEFIT PAY-
7 MENTS.—The term ‘request for benefit pay-
8 ments’ means a request, for payment of benefits
9 by a group health plan for medical care, which
10 is made by, or (if expressly authorized) on be-
11 half of, a participant or beneficiary after such
12 medical care has been provided.

13 “(B) REQUIRED DETERMINATION OF MED-
14 ICAL NECESSITY.—The term ‘required deter-
15 mination of medical necessity’ means a deter-
16 mination required under a group health plan
17 solely that proposed medical care meets, under
18 the facts and circumstances at the time of the
19 determination, the plan’s requirements for med-
20 ical appropriateness or necessity (which may be
21 subject to exceptions under the plan for fraud
22 or misrepresentation), irrespective of whether
23 the proposed medical care otherwise meets
24 other terms and conditions of coverage, but
25 only if such determination does not constitute

1 an advance determination of coverage (as de-
2 fined in subparagraph (C)).

3 “(C) ADVANCE DETERMINATION OF COV-
4 ERAGE.—The term ‘advance determination of
5 coverage’ means a determination under a group
6 health plan that proposed medical care meets,
7 under the facts and circumstances at the time
8 of the determination, the plan’s terms and con-
9 ditions of coverage (which may be subject to ex-
10 ceptions under the plan for fraud or misrepre-
11 sentation).

12 “(D) REQUEST FOR ADVANCE DETERMINA-
13 TION OF COVERAGE.—The term ‘request for ad-
14 vance determination of coverage’ means a re-
15 quest for an advance determination of coverage
16 of medical care which is made by, or (if ex-
17 pressly authorized) on behalf of, a participant
18 or beneficiary before such medical care is pro-
19 vided.

20 “(E) REQUEST FOR EXPEDITED ADVANCE
21 DETERMINATION OF COVERAGE.—The term ‘re-
22 quest for expedited advance determination of
23 coverage’ means a request for advance deter-
24 mination of coverage, in any case in which the

1 proposed medical care constitutes accelerated
2 need medical care.

3 “(F) REQUEST FOR REQUIRED DETER-
4 MINATION OF MEDICAL NECESSITY.—The term
5 ‘request for required determination of medical
6 necessity’ means a request for a required deter-
7 mination of medical necessity for medical care
8 which is made by or on behalf of a participant
9 or beneficiary before the medical care is pro-
10 vided.

11 “(G) REQUEST FOR EXPEDITED REQUIRED
12 DETERMINATION OF MEDICAL NECESSITY.—
13 The term ‘request for expedited required deter-
14 mination of medical necessity’ means a request
15 for required determination of medical necessity
16 in any case in which the proposed medical care
17 constitutes accelerated need medical care.

18 “(H) ACCELERATED NEED MEDICAL
19 CARE.—The term ‘accelerated need medical
20 care’ means medical care in any case in which
21 an appropriate physician has certified in writing
22 (or as otherwise provided in regulations of the
23 Secretary) that the participant or beneficiary is
24 stabilized and—

1 “(i) that failure to immediately pro-
2 vide the care to the participant or bene-
3 ficiary could reasonably be expected to re-
4 sult in—

5 “(I) placing the health of such
6 participant or beneficiary (or, with re-
7 spect to such a participant or bene-
8 ficiary who is a pregnant woman, the
9 health of the woman or her unborn
10 child) in serious jeopardy;

11 “(II) serious impairment to bod-
12 ily functions; or

13 “(III) serious dysfunction of any
14 bodily organ or part; or

15 “(ii) that immediate provision of the
16 care is necessary because the participant
17 or beneficiary has made or is at serious
18 risk of making an attempt to harm himself
19 or herself or another individual.

20 “(I) INITIAL DECISION PERIOD.—The term
21 ‘initial decision period’ means a period of 30
22 days, or such longer period as may be pre-
23 scribed in regulations of the Secretary.

24 “(J) INTERNAL REVIEW PERIOD.—The
25 term ‘internal review period’ means a period of

1 30 days, or such longer period as may be pre-
2 scribed in regulations of the Secretary.

3 “(K) ACCELERATED NEED DECISION PE-
4 RIOD.—The term ‘accelerated need decision pe-
5 riod’ means a period of 5 days, or such longer
6 period as may be prescribed in regulations of
7 the Secretary.

8 “(L) RECONSIDERATION PERIOD.—The
9 term ‘reconsideration period’ means a period of
10 25 days, or such longer period as may be pre-
11 scribed in regulations of the Secretary, except
12 that—

13 “(i) in the case of a decision involving
14 urgent medical care, such term means the
15 urgent decision period; and

16 “(ii) in the case of a decision involving
17 accelerated need medical care, such term
18 means the accelerated need decision period.

19 “(M) FILING COMPLETION DATE.—The
20 term ‘filing completion date’ means, in connec-
21 tion with a group health plan, the date as of
22 which the plan is in receipt of all information
23 reasonably required (in writing or in such other
24 reasonable form as may be specified by the
25 plan) to make an initial coverage decision.

1 “(N) REVIEW FILING DATE.—The term
2 ‘review filing date’ means, in connection with a
3 group health plan, the date as of which the ap-
4 propriate named fiduciary (or the independent
5 medical expert or experts in the case of a review
6 under paragraph (4)) is in receipt of all infor-
7 mation reasonably required (in writing or in
8 such other reasonable form as may be specified
9 by the plan) to make a decision to affirm, mod-
10 ify, or reverse a coverage decision.

11 “(O) MEDICAL CARE.—The term ‘medical
12 care’ has the meaning provided such term by
13 section 733(a)(2).

14 “(P) HEALTH INSURANCE COVERAGE.—
15 The term ‘health insurance coverage’ has the
16 meaning provided such term by section
17 733(b)(1).

18 “(Q) HEALTH INSURANCE ISSUER.—The
19 term ‘health insurance issuer’ has the meaning
20 provided such term by section 733(b)(2).

21 “(R) WRITTEN OR IN WRITING.—

22 “(i) IN GENERAL.—A request or deci-
23 sion shall be deemed to be ‘written’ or ‘in
24 writing’ if such request or decision is pre-
25 sented in a generally recognized printable

1 or electronic format. The Secretary may by
2 regulation provide for presentation of in-
3 formation otherwise required to be in writ-
4 ten form in such other forms as may be
5 appropriate under the circumstances.

6 “(ii) MEDICAL APPROPRIATENESS OR
7 INVESTIGATIONAL ITEMS OR EXPERI-
8 MENTAL TREATMENT DETERMINATIONS.—

9 For purposes of this subparagraph, in the
10 case of a request for advance determina-
11 tion of coverage, a request for expedited
12 advance determination of coverage, a re-
13 quest for required determination of medical
14 necessity, or a request for expedited re-
15 quired determination of medical necessity,
16 if the decision on such request is conveyed
17 to the provider of medical care or to the
18 participant or beneficiary by means of tele-
19 phonic or other electronic communications,
20 such decision shall be treated as a written
21 decision.”.

22 **SEC. 3. CLARIFICATION OF ERISA PREEMPTION RULES.**

23 (a) IN GENERAL.—Section 514 of the Employee Re-
24 tirement Income Security Act of 1974 (29 U.S.C. 1144)
25 is amended—

1 (1) by redesignating subsection (d) as sub-
2 section (e); and

3 (2) by inserting after subsection (c) the fol-
4 lowing new subsection:

5 “(d) The procedures and remedies required or pro-
6 vided under sections 502 and 503 in connection with—

7 “(1) review of claims for benefits under em-
8 ployee benefit plans and for review of decisions deny-
9 ing such claims (including review of coverage deci-
10 sions referred to in section 503(b) and decisions
11 upon review of such coverage decisions), and

12 “(2) causes of action brought to recover plan
13 benefits, to enforce rights under the terms of the
14 plan or this title, or to clarify rights to future bene-
15 fits under the terms of the plan or this title,

16 are the exclusive procedures and remedies with respect to
17 any such review or cause of action and supersede any pro-
18 vision of State law providing for any such review or cause
19 of action.”.

20 (b) CONFORMING AMENDMENT.—Section
21 514(b)(2)(A) of such Act (42 U.S.C. 1144(b)(2)(A)) is
22 amended by inserting “or subsection (d)” after “subpara-
23 graph (B)”.

1 **SEC. 4. EFFECTIVE DATE.**

2 (a) **IN GENERAL.**—The amendments made by this
3 Act shall apply with respect to grievances arising in plan
4 years beginning on or after January 1 of the second cal-
5 endar year following 12 months after the date the Sec-
6 retary of Labor issues all regulations necessary to carry
7 out amendments made by this Act.

8 (b) **LIMITATION ON ENFORCEMENT ACTIONS.**—No
9 enforcement action shall be taken, pursuant to the amend-
10 ments made by this Act, against a group health plan or
11 health insurance issuer with respect to a violation of a re-
12 quirement imposed by such amendments before the date
13 of issuance of final regulations issued in connection with
14 such requirement, if the plan or issuer has sought to com-
15 ply in good faith with such requirement.

16 (c) **COLLECTIVE BARGAINING AGREEMENTS.**—Any
17 plan amendment made pursuant to a collective bargaining
18 agreement relating to the plan which amends the plan
19 solely to conform to any requirement added by this Act
20 shall not be treated as a termination of such collective bar-
21 gaining agreement.

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